ATTACHMENT D PART 3

BP-S360.060 HEALTH INTAKE ASSESSMENT/HISTORY PART
FEB 05
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISO

Inmate Name:	Register No:	Institution:
Leslie Kelly	26540-39	TAL- FDC

Inmate Received From: ☐ Court ☐ Jail ☐ Self-surrender ☑ Other INTAKE SCREENING

INMATE : PLEASE COMPLETE ITEMS 1-14. For non-English speaking, template provided in: ☐ Spanish ☐ Other

1. MEDICATIONS: Please list all current medications, doses, and date/time last taken:

2. ALLERGIES: Please check any allergies you have had.

☐ Medications:

☐ Foods (list): ☐ Other:

3. MEDICAL ILLNESSES: Please check any conditions you currently have or have had in the past.

☐ Heart attack/disease	☐ Blood clot	☐ Angina	☐ Diabetes	☐ Sickle cell disease
☐ Lung disease	☐ Asthma	☐ Stroke	☐ High blood pressure	☐ Seizures/Epilepsy
☐ Cancer Type: When:		☐ Other		

4. INFECTIOUS DISEASE: Please check any conditions you currently have or have had in the past.

☐ Positive TB skin test	☐ Tuberculosis ☐ Cough up blood ☐ Persistent cough - how long? ☐ Night sweats		
☐ Chickenpox or shingles	☐ Gonorrhea	☐ Chlamydia	☐ Do you currently have a rash, open sore or wound? Where:
☐ HIV (how long)	☐ Hepatitis (Type):	☐ Herpes	☐ Blood transfusion When:
☐ Recent travel outside US: When: Where:	☐ Syphilis ☐ Treated? When: Where:		Why:

Are you at risk for HIV and/or hepatitis due to sharing needles, high-risk sex or tattooing? ☐ Yes ☐ No ☐ Don't know
(If you do not know, please discuss any concerns with a health care provider and request testing if appropriate)

5. NERVOUS CONDITIONS: Please check any conditions you currently have or have had in the past.

Have you ever had a mental illness? ☐ No ☐ Yes Specify:

☐ Suicidal thoughts When:	☐ Head injury When: How:	☐ Loss of Consciousness When: How:
☐ Suicide Attempt When:	How:	

6. DRUGS AND ALCOHOL: Are you now using, or have you in the past used any of the following:

SUBSTANCE	HOW USED (Needle, Smoked, Snorted, Pills	DATE OF LAST USE
☐ Tranquilizers (Valium, Xanax, etc)		

☐ Barbituates (phenobarbital, Seconal, other)	NO	
☐ LSD/Hallucinogens/PCP		
☐ Marijuana		
☐ Other		

Alcohol History: Please complete the following:

Type used: (beer, wine, vodka, etc.)	How often: (daily, weekly)	Usual Amount	Date of last drink

Have you ever had, or are you now having, any withdrawal symptoms when you have stopped using drugs or alcohol: ☑ No ☐ Yes
If yes, please describe:

Do you use:

Tobacco: ☐ Yes ☑ No How much? _____ Pack/Day How long? _____ Years

7. PAIN ASSESSMENT:

Do you currently suffer from any painful condition? ☐ No ☐ Yes - Location: Head Chest

8. DENTAL: Do you currently have any of the following:

☐ Pain in teeth or mouth	☐ Swelling in mouth, jaws, or neck	☐ Dental emergency which you feel must be addressed immediately

9. HISTORY OF ABUSE: Please complete the following: if applicable: ☐ Not applicable

TYPE OF ABUSE	WHAT AGE(s) OR WHEN
☐ Physical	
☐ Emotional	
☐ Sexual	

10. FEMALE HEALTH: Women please complete the following:

Date of last menstrual period: _____ # of Pregnancies: _____	Are you pregnant now?: ☐ Yes ☐ No ☐ Don't know	
Date of last pap smear: _____ Results: ☐ Normal ☐ Abnormal ☐ Don't know		Have you ever had any of the following? (If yes, what year?)
Date of last mammogram: _____ Results: ☐ Normal ☐ Abnormal ☐ Don't know		☐ Abnormal Pap _____
Type of Birth Control: ☐ Birth Control Pills ☐ IUD ☐ Diaphragm ☐ None ☐ Other:		☐ Breast Biopsy _____
Are you taking hormones for menopause or after hysterectomy? ☐ Yes ☐ No	Check vaccinations you have had: ☐ Measles ☐ Mumps ☐ Rubella	☐ Hysterectomy _____

11. ALL INMATES - Please describe any other medical or mental health concerns you have:

12. DIET:

☐ Diabetic	☐ Low salt	☐ Low fat	☐ Vegetarian	☐ Other _____
Current weight:		Usual weight:		

13. IMMUNIZATIONS: Have you received any of the following vaccinations:

☐ Tetanus (when): _____	☐ Hepatitis A	☐ Hepatitis B	☐ Pneumonia ["Pneumovax"] (when): _____

I have answered all questions truthfully and to the best of my ability.

Inmate Signature: X Zachi Kelly	Date: 11/23/05

BP-S360.060 MEDICAL HISTORY REPORT CDFRM MAY 94

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(THIS INFORMATION IS FOR OFFICIAL AND MEDICAL CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME	2. REGISTER NUMBER
Kelly Leslie Romeo	26564-039
3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION / 5. EXAMINATION FACILITY

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATION CURRENTLY USED (Follow by description of past history, if complaint arises)

7. HAVE YOU EVER (Please check each item)

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Cough up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU (Please check each item)

YES	NO	(Check each item)
✓		Wear glasses or contacts lens
✓		Have vision in both eyes
	✓	Wear hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to				Epilepsy or fits
	✓		Rheumatic fever		✓		drug or medicine				Car, train, sea or air sickness
✓			Swollen or painful			✓	Broken bones				Frequent trouble sleeping
✓			joints		✓		Tumors, growth, cyst, cancer				Depression or excessive worry
	✓		Frequent or severe		✓		Rupture/hernia				Loss of memory or amnesia
✓			headache		✓		Piles or rectal disease				Nervous trouble of any sort
	✓		Dizziness or fainting		✓		Frequent or				Periods of unconsciousness
	✓		spells		✓		painful urination				Have you ever had
	✓		Eye trouble		✓		Bed wetting since age 12				homosexual contact?
	✓		Ear, nose, throat trouble		✓		Kidney stone or				Been exposed to AIDS
	✓		Hearing loss		✓		blood in urine				Alcohol Use (Excessive)
	✓		Chronic, frequent colds		✓		Sugar, albumin in urine				Drug Use/Addiction
	✓		Severe tooth, gum trouble		✓		VD-Syphilis, gonorrhea,				Marijuana
	✓		Sinusitis		✓		etc.				Cocaine
	✓		Hay Fever		✓		Recent gain or loss of				Heroin
	✓		Head injury		✓		weight				L.S.D.
	✓		Skin disease		✓		Arthritis, Rheumatism,				Amphetamines
	✓		Thyroid trouble		✓		or Bursitis				Others: (Specify)
	✓		Tuberculosis	✓			Bone, joint or				
	✓		Asthma		✓		other deformity				Alcohol or drug
	✓		Shortness of breath		✓		Lameness				Withdrawal Problems
✓			Pain, pressure in chest		✓		Loss of finger or toe				

(This form may be replicated via WP) This form replaces BP-360(60) dated January 1986

FTCOKL-01

			Chronic cough				Painful or "Trick" shoulder or elbow				
			Palpitation or pounding heart				Recurrent back pain				10. FEMALES ONLY HAVE YOU EVER
			Heart trouble				"Trick" or locked				Been treated for a female disorder
			High or Low blood pressure	✓			Foot trouble				Had a change in menstrual pattern
			Cramps in your legs				Neuritis				ARE YOU PREGNANT
			Frequent indigestion				Paralysis (include infantile)				SUSPECT YOU ARE PREGNANT
			Stomach, liver, or intestinal trouble				Gall bladder trouble or gallstones				
			Jaundice or hepatitis								

11. WHAT IS YOUR OCCUPATION?

12. ARE YOU (check one) ☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or bee unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury notes? (If yes, specify when, where, and give details.)
	✓	B. Inability to perform certain motions.			
	✓	C. Inability to assume certain positions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
	✓	D. Other medical reasons (If you, give reasons.)			
	✓	14. Have you, ever been treated for mental condition? (If yes, specify when, where, and give details.)		✓	20. Have you ever been rejected for military service because of physical, mental or other reason? (If yes, give date, and reason for rejections?)
	✓	15. Have you ever been denied life insurance? Reason give details.)		✓	21. Have your ever been discharged from military service because of physical mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
	✓	16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, what amount, when, why.)
	✓	17. Have you ever been a patient in any type of hospital? (If yes, specify when, where why, and name of doctor and complete address of hospital.)			

I certify that I have reviewed the forgoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of my doctors, hospitals, or clinics mentioned above to furnish the government a complete transcript of my medical record.

TYPED OR PRINTED NAME OR EXAMINEE | SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT_____TRANSFER _____P.V._____

OTHER _____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG HOW MUCH, HOW OFTEN HOW USED. WHEN WERE THEY LAST USED:

HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? _____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ____

WHAT ARRANGEMENTS HAVE BEEN MADE? _____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED _____

GENERAL POPULATION ____ YES ____ NO _____

TYPE EXTENT OF LIMITATION _____

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

TYPE OR PRINT NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
L. T. Genzer, RN FTC, OKC	MAY 24 2004		

Food or Drug Allergies: NKA: Allergies: _____

Current Medical Status: No Complaints: Complaint of _____

TB Signs and Symptom(s): None; cough, hemoptysis, night sweats, wt. loss

BP-S354.060 INTAKE SCREENI (MEDICAL) COFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
	12-1-05	1030

Kelly, Leslie R. **26864-039** | Register Number
DOB: 12-17-62
FCI Bennettsville

C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)
N/A

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
S Deese RN	12-1-05	1555

Medical Staff Title
Nurse

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994

FCI BENNETTSVILLE

BP-S354.060 INTAKE SCREENI_ (MEDICAL) CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP Atl	11-30-05	

Inmate's Name	Register Number
Kelly Keolie	26864039

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☐ yes; ☒ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☐ yes; ☒ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
	11-30-05	1500

Medical Staff Title

R. Ognes, MLP
USP Atlanta

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

Name: LESLIE KELLY
ID: 59554

9/23/2005 12:00:54

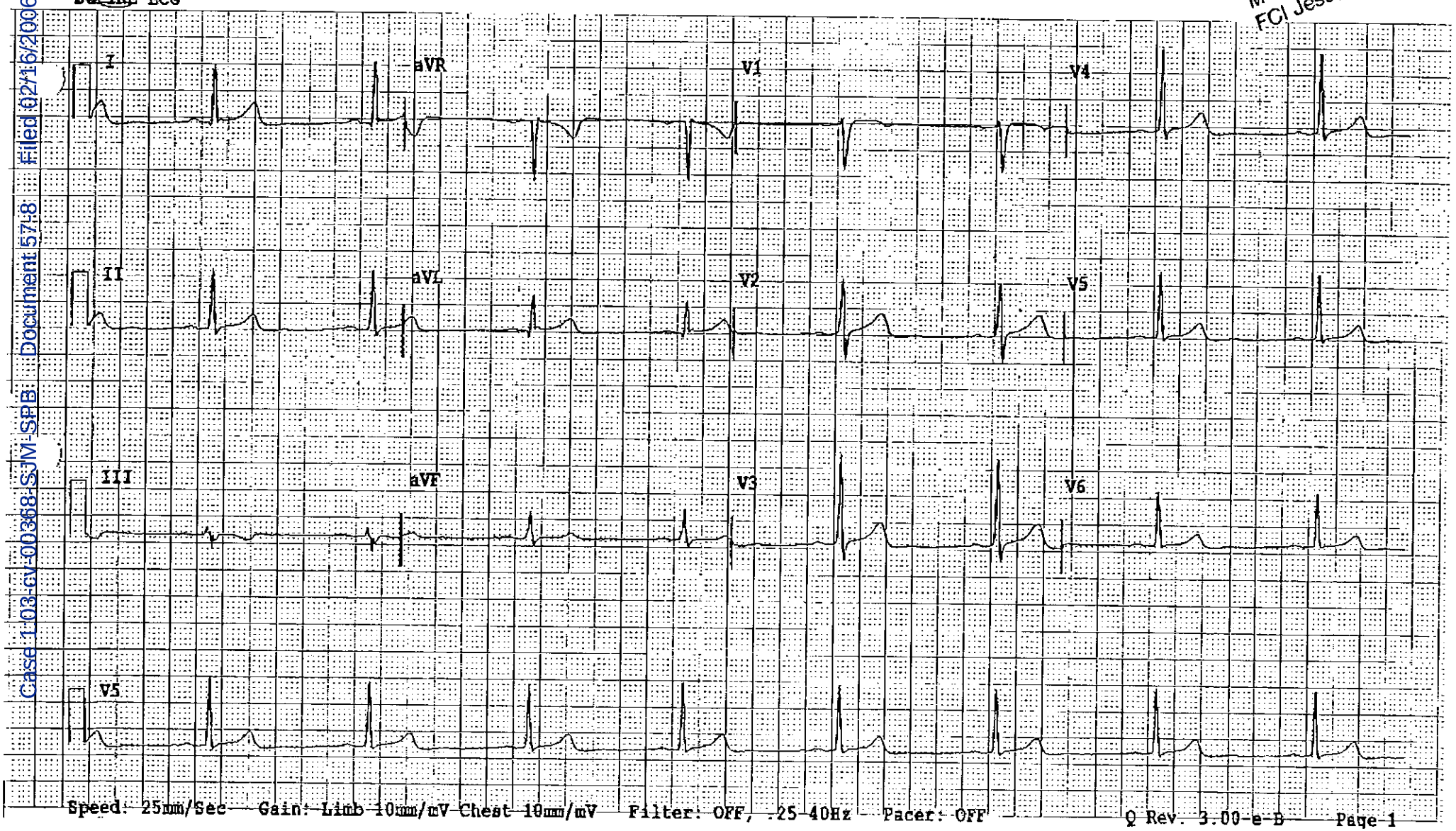
HR:	52	Medicine 1:	
BP:		Medicine 2:	
Age:	42 Years	Clin. Class 1:	
Sex:	Male	Clin. Class 2:	
Race:	Black	Department:	CARDIO CONSULTANTS
Height:	0 in	Technician:	NINA
Weight:	0 lbs	Physician:	DR MILLER

EKG:
1. Sinus bradycardia.
2. Normal tracing.

JAMES W. MILLER, M.D./wg
cc: Dr. Chipi
T:09/23/05

M. Chipi, MD
Medical Officer
FCI Jesup, Ga.

SUPINE ECG

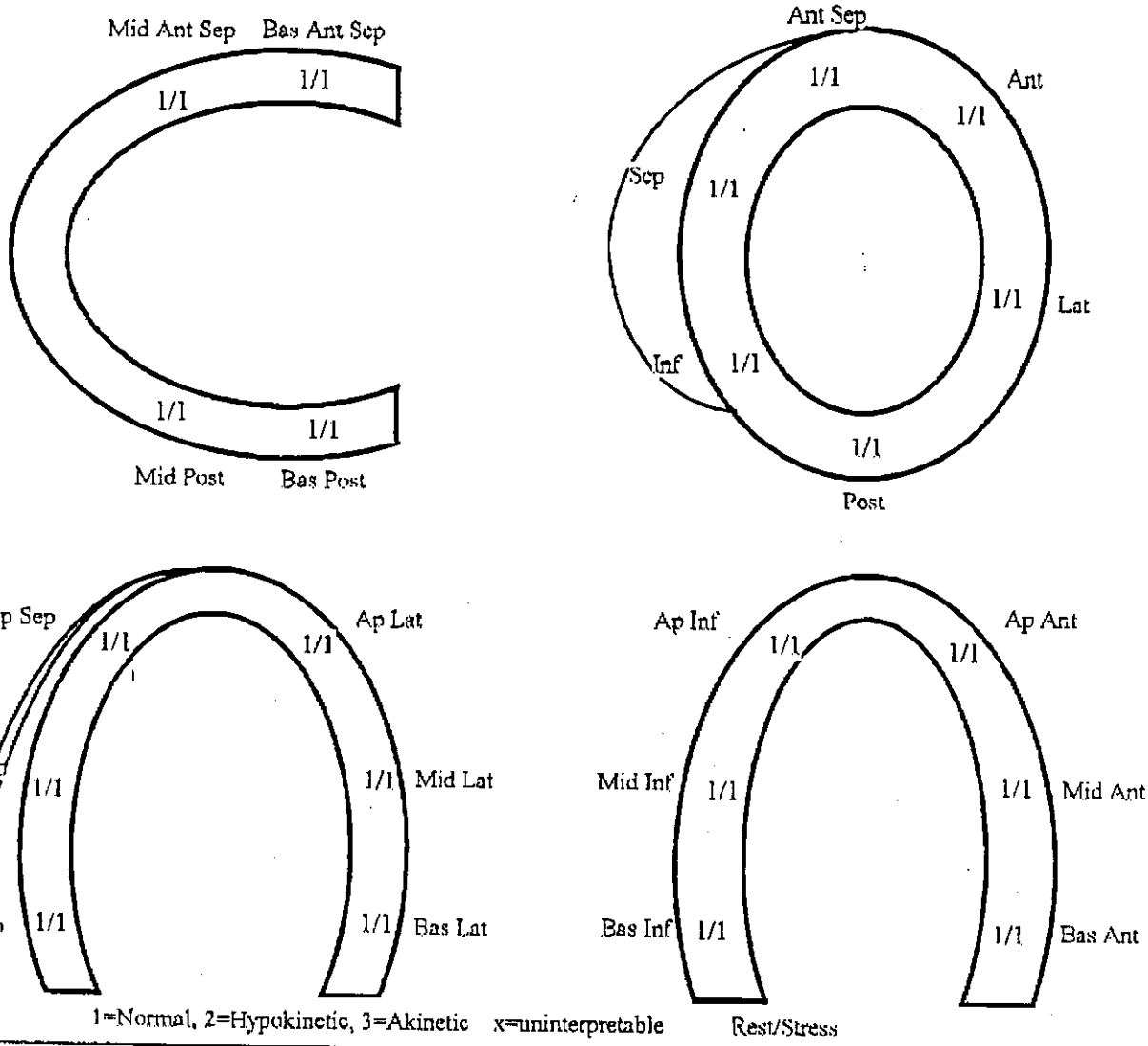


Cardiovascular Consultan_ P.C.

Stress Echocardiogram Report

Patient: Kelly, Leslie **DOB:** 12/17/67 **Chart #:** 59554 **Tape #:** Miller-69
Date: 09/23/05

cc: Dr. Chipi (FCI, Jesup)



Stress Echocardiogram: He has excellent contractility throughout at rest and with exercise, and with no evidence of dyskinesia, hypokinesia or akinesia.

Impression:

1. Normal Stress Echo with no evidence of ischemia.

JAMES W. MILLER, M.D./wg
cc: Dr. Chipi (Jesup)
T:09/23/05

M. Chipi, MD
Medical Officer
FCI Jesup, Ga.

Name: LESLIE KELLY
ID: 59554 9/23/2005 12:26:2

HR: 123 Phase: Recovery
BP: Exercise Time: 09:00
RPE: Stage/Time: -/00:20
Workload: 0.0 mph 7.9 % grade
Protocol: Bruce

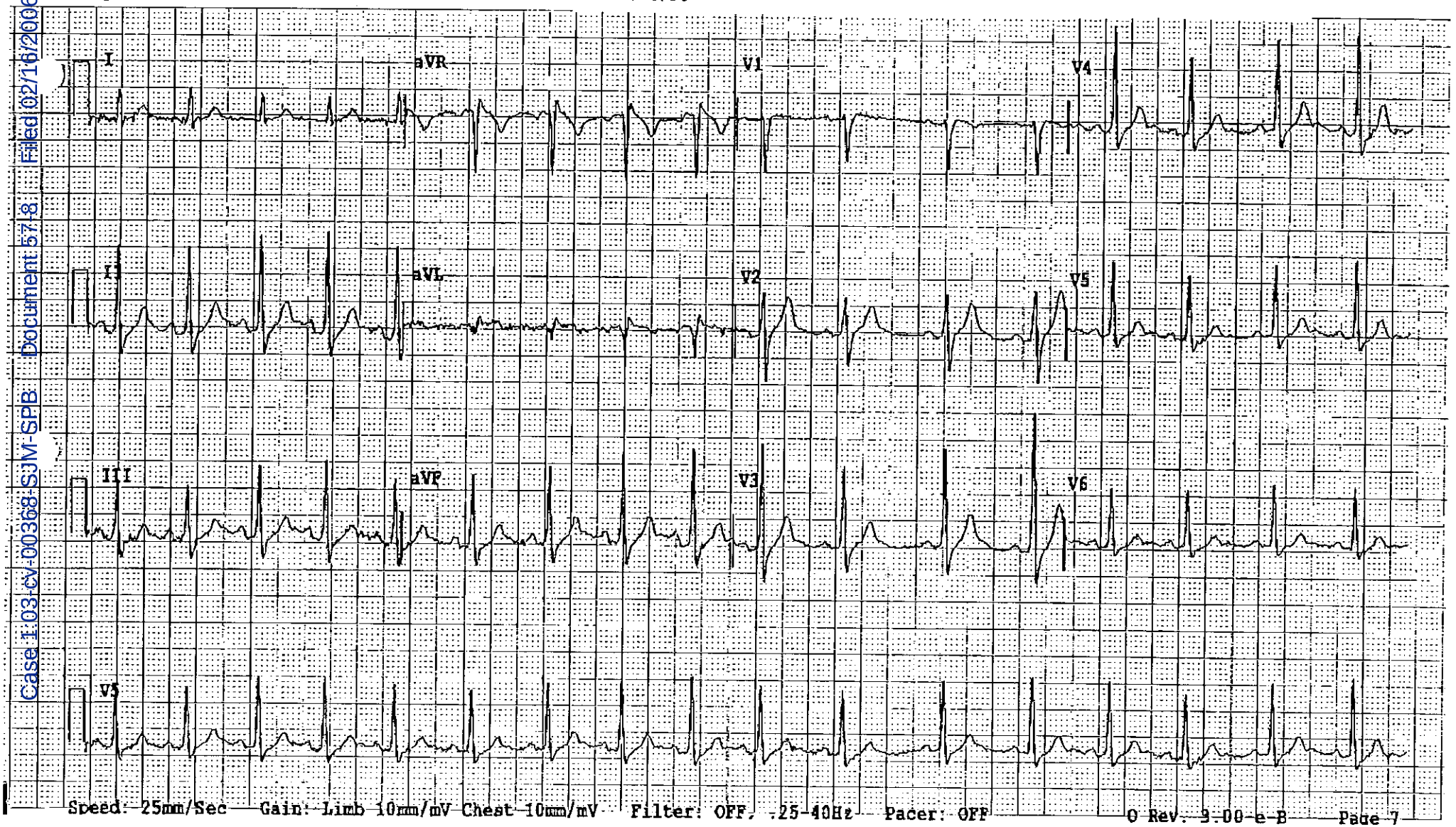
Treadmill Stress Test: He exercised for 9 minutes which is the end of stage III of the Bruce protocol to a heart rate of 144. BP 170/60. The test was stopped due to dyspnea. He had no chest pain. No ST segment change or arrhythmia seen.

Impression:

1. Excellent exercise capacity.
2. Negative test for ischemia by EKG and clinical criteria.

JAMES W. MILLER, M.D./wg
cc: Dr. Chipi
T:09/23/05

M. Chipi, MD
Medical Officer
FCI Jesup, Ga.



SF 513-110 NSN 7540-00-634-4127

MEDICAL RECORD — CONSULTATION SHEET

(6)

REQUEST

TO: Cardiology FROM: Pollard DATE OF REQUEST: 5/19/05

REASON FOR REQUEST (Complaints and findings) 42 yr old B/m c long hx of HTN + SMAH – need stress test – chest pain

Follow up visit ( )

Medication Allergies: ↑ lipid Current Medications:

PROVISIONAL DIAGNOSIS:

DOCTOR'S SIGNATURE APPROVED

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

Consultant's findings and recommendations:

9/23 @ 10:40

Stress echo is normal

No evidence of ischemia

Good LV function

Full report to follow

Return to FCI Jesup Health Services with escorting officer. Thank you.

SIGNATURE AND TITLE DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; rank; rate; hospital or medical facility)

[illegible]-039

1[illegible]/17/62

FCI JESUP, GA.

CONSULTATION SHEET

M Chipi, MD
Medical Officer
FCI Jesup, Ga.

FCI/FSL/FPC Jesup GA

CARDIOVASCULAR C ,SULTANTS, P.C.
4700 WATERS AVENUE, SUITE 400
SAVANNAH, GEORGIA 31404

JAMES W. MILLER, M.D.
JAMES S. GAINER, JR., M.D.
MARK G. JENKINS, M.D.
JOHN G. SPELLMAN, M.D.
PABLO M. ELIZALDE, M.D.
BRETT C. BURGESS, M.D.

TELEPHONE (912) 355-0070
(800) 641-0070
FAX (912) 355-3220

C. WALKER BEESON, II, M.D.
EMERITUS

PRACTICE LIMITED TO
CARDIOVASCULAR DISEASE

September 23, 2005

Attention: Dr. Chipi
Federal Correctional Institution
2600 Highway 301, South
Jesup, GA 31545

RE: **Leslie Kelly**

Dear Dr. Chipi:

Thank you for letting me see Leslie Kelly for the Stress Echo.

The test is completely normal. He has good LV function. There is no evidence of ischemia.

Thank you again for letting me see him. I hope this is helpful in his management. Please give me a call if you have any questions.

Sincerely,

James W. Miller, M.D.

JWM/wg

Enclosures

M. Chipi, M.D
Medical Officer
FCI Jesup, Ga.

U.S. MEDICAL CENTERS FOR FEDERAL PRISONERS
Laboratory, 1900 W. Sunshine
SPRINGFIELD, MISSOURI 65808
(417) 862-7041

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***** SENSITIVE-LIMITED OFFICIAL USE *****
FINAL REPORT

==========

Register Number : 26864-039
Name : KELLY, LESLIE
Location : FCI JESUP (JES)
Admit. Physician: WICKARD
Order. Physician: WICKARD
Collected : 03/09/05 @ 12:00 by: REFE

Age : 42yr
Sex : M
Room :
Accession Number : 1954

Test	Result	Flag	Reference Range/Units	Tech
LIPID TESTING				
COMP. METABOLIC				
LIVER PROFILE				
Glucose	91		70 - 110 mg/dL	MS CK
Urea Nitrogen	13		7 - 22 mg/dL	MS CK
Creatinine	1.1		0.6 - 1.6 mg/dL	MS CK
SodiumI	140		137 - 148 mmol/L	MS CK
Potassium	4.6		3.5 - 5.0 mmol/L	MS CK
Chloridel	105		99 - 114 mmol/L	MS CK
Calciuml	8.9		8.5 - 10.9 mg/dL	MS CK
Total Protein	6.9		6.0 - 8.2 g/dL	MS CK
Albumin	3.7		3.6 - 5.1 g/dL	MS CK
Alkaline Phos.	88		41 - 133 U/L	MS CK
AST(SGOT)	24		11 - 55 U/L	MS CK
LDH	414		354 - 705 U/L	MS CK
Total Bilirubinl	0.4		0.2 - 1.3 mg/dL	MS CK
Cholesterol	163		140 - 200 mg/dL	MS CK
Triglycerides	53		30 - 200 mg/dL	MS CK
A/G Ratio	1.14		1.00 - 2.30	MS CK
Globulin	3.2		2.0 - 3.7 g/dL	MS CK
ALT1(SGPT)	55		11 - 66 U/L	MS CK
Direct Bilirubin	0.1		0.0 - 0.5 mg/dL	MS CK
Gamma GTl	31		8 - 78 U/L	MS CK
Bilirubin Unconj	0.3		0.0 - 1.1 mg/dL	MS CK
Bun/Creat Ratio	11.6		5.0 - 30.0	MS CK
HDL-Cholesterol1	39		29 - 67 mg/dL	RS TE
	Other factors critical to assessment of CHD risk - Overweight, Blood Pressure, Smoking and Familial History.			
VLDL	11		mg/dL	HS TE
LDL Cholesterol	113		62 - 130 mg/dL	HS TE
Chol/HDL Ratio	4.2		3.4 - 5.0	HS TE
Bilirubin Conjug	0.0		0.0 - 0.3 mg/dl	MS CK
CBC				
White Blood Cell	5.8		4.3 - 11.1 10^3/uL	KS TE
Red Blood Cells	5.46		4.46 - 5.78 10^6/uL	KS TE
Hemoglobin	14.8		13.6 - 17.6 g/dL	KS TE

Paul W. Wickard, PAC
Physician Assistant
FCI/FPC/FSL Jesup, Ga.

Legend

LO=Low AL=Alarm Low EL=Elevated Low HI=High AH=Alarm High EH=Elevated High AB=Abnormal

Name : KELLY, LESLIE
Register Number : 26864-039
Printed : 03/10/2005 @ 16:18

Location : JES

U.S. MEDICAL CENTERS FOR FEDERAL PRISONERS
Laboratory, 1900 W. Sunshine
SPRINGFIELD, MISSOURI 65808
(417) 862-7041

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***** SENSITIVE-LIMITED OFFICIAL USE *****
FINAL REPORT

==========

Register Number : 26864-039
Name : KELLY, LESLIE
Location : FCI JESUP (JES)
Admit. Physician: WICKARD
Order. Physician: WICKARD
Collected : 03/09/05 @ 12:00 by: REFE

Age : 42yr
Sex : M
Room :
Accession Number : 1954

Test	Result	Flag	Reference Range/Units	Tech
Hematocrit	45.3		40.2 - 51.4 %	KS TE
MCV	82.8		82.5 - 96.5 fL	KS TE
MCH	27.1		27.1 - 34.3 pg	KS TE
MCHC	32.7	LO	33.0 - 35.0 g/dL	KS TE
RDW	14.4	HI	12.0 - 14.0 %	KS TE
PLT	194		130 - 374 10^3/uL	KS TE
MPV	10.3		6.9 - 10.5 fL	KS TE
AUTODIFF				
Neutrophils	48.8		43.0 - 67.0 %	KS TE
Lymphocytes	41.3		21.0 - 45.0 %	KS TE
Monocytes	6.8		5.0 - 13.0 %	KS TE
Eosinophils	1.6		0.0 - 7.0 %	KS TE
Basophils	1.5	HI	0.0 - 1.0 %	KS TE
Neutrophil #	2.8		1.9 - 6.7 10^3/uL	KS TE
Lymphocyte #	2.4		1.3 - 3.7 10^3/uL	KS TE
Monocyte #	0.4		0.3 - 1.1 10^3/uL	KS TE
Eosinophil #	0.1		0.0 - 0.5 10^3/uL	KS TE
Basophil #	0.1		0.0 - 0.1 10^3/uL	KS TE

Paul W. Wickard, PAC
Physician Assistant
FCI/FPC/FSL Jesup, Ga.

LYNSBURGS, M.D.
FCI/FPC JESUP, GA

Legend

LO=Low AL=Alarm Low SL=Elevated Low HI=High AH=Alarm High EH=Elevated High AB=Abnormal

U.S. MEDICAL CENTERS FOR FEDERAL PRISONERS
Laboratory, 1900 W. Sunshine
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***** SENSITIVE-LIMITED OFFICIAL USE *****
FINAL REPORT

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Register Number : 26864-039
Name : KELLY, LESLIE
Location : FCI JESUP (JES)
Admit. Physician: WICKARD
Order. Physician: WICKARD
Collected : 11/30/04 @ 13:00 by: RE

Age : 41yr
Sex : M
Room :
Accession Number : 4861

Test	Result	Flag	Reference Range/Units	Tech
LIPID TESTING				
COMP. METABOLIC				
LIVER PROFILE				
Glucose	87		70 - 110 mg/dL	LN CK
Urea Nitrogen	14		7 - 22 mg/dL	LN CK
Creatinine	1.2		0.6 - 1.6 mg/dL	LN CK
SodiumI	142		137 - 148 mmol/L	LN CK
Potassium	4.4		3.5 - 5.0 mmol/L	LN CK
Chloride1	107		99 - 114 mmol/L	LN CK
Calcium1	9.0		8.5 - 10.9 mg/dL	LN CK
Total Protein	7.3		6.0 - 8.2 g/dL	LN CK
Albumin	4.1		3.6 - 5.1 g/dL	LN CK
Alkaline Phos.	82		41 - 133 U/L	LN CK
AST(SGOT)	22		11 - 55 U/L	LN CK
LDH	424		354 - 705 U/L	LN CK
Total Bilirubin1	0.2		0.2 - 1.3 mg/dL	LN CK
Cholesterol	257	HI	140 - 200 mg/dL	LN CK
Triglycerides	67		30 - 200 mg/dL	LN CK
A/G Ratio	1.28		1.00 - 2.30	LN CK
Globulin	3.2		2.0 - 3.7 g/dL	LN CK
ALT1(SGPT)	44		11 - 66 U/L	LN CK
Direct Bilirubin	0.0		0.0 - 0.5 mg/dL	LN CK
Gamma GT1	28		8 - 78 U/L	LN CK
Bilirubin Unconj	0.4		0.0 - 1.1 mg/dL	LN CK
Bun/Creat Ratio	11.8		5.0 - 30.0	LN CK
HDL-Cholesterol1	38		29 - 67 mg/dL	LN CK
	Other factors critical to assessment of CHD risk - Overweight, Blood Pressure, Smoking and Familial History.			
VLDL	13		mg/dL	HS CK
LDL Cholesterol	206	HI	62 - 130 mg/dL	HS CK
Chol/HDL Ratio	6.8	HI	3.4 - 5.0	HS CK
TSH	1.06		0.30 - 7.00 uIU/mL	RS TE
Bilirubin Conjug	0.0		0.0 - 0.3 mg/dl	LN CK
CBC				
White Blood Cell	6.3		4.3 - 11.1 10^3/uL	JN RY
Red Blocd Cells	5.45		4.46 - 5.78 10^6/uL	JN RY

Paul W. Wickard, PAC
Physician Assistant
FCI/FPC/FSL Jesup, Ga.

Legend

LO=Low AL=Alarm Low EL=Elevated Low HI=High AH=Alarm High EH=Elevated High AB=Abnormal

M. Chipi, MD
Medical Officer
FCI Jesup, Ga.

U.S. MEDICAL CENTERS FOR FEDERAL PRISONERS
Laboratory, 1900 W. Sunshine
SPRINGFIELD, MISSOURI 65808
(417) 862-7041

*** SENSITIVE-LIMITED OFFICIAL USE ***
FINAL REPORT

Register Number : 26864-039
Name : KELLY, LESLIE
Location : FCI JESUP (JES)
Admit. Physician: WICKARD
Order. Physician: WICKARD
Collected : 11/30/04 @ 13:00 by: RE

Age : 41yr
Sex : M
Room :
Accession Number : 4861

Test	Result	Flag	Reference Range/Units	Tech
Hemoglobin	15.0		13.6 - 17.6 g/dL	JN RY
Hematocrit	45.5		40.2 - 51.4 %	JN RY
MCV	83.5		82.5 - 96.5 fL	JN RY
MCH	27.5		27.1 - 34.3 pg	JN RY
MCHC	32.9	LO	33.0 - 35.0 g/dL	JN RY
RDW	15.1	HI	12.0 - 14.0 %	JN RY
PLT	201		130 - 374 10^3/uL	JN RY
MPV	10.7	HI	6.9 - 10.5 fL	JN RY
AUTODIFF				
Neutrophils	53.7		43.0 - 67.0 %	JN RY
Lymphocytes	39.6		21.0 - 45.0 %	JN RY
Monocytes	4.7	LO	5.0 - 13.0 %	JN RY
Eosinophils	1.9		0.0 - 7.0 %	JN RY
Basophils	0.1		0.0 - 1.0 %	JN RY
Neutrophil #	3.4		1.9 - 6.7 10^3/uL	JN RY
Lymphocyte #	2.5		1.3 - 3.7 10^3/uL	JN RY
Monocyte #	0.3		0.3 - 1.1 10^3/uL	JN RY
Eosinophil #	0.1		0.0 - 0.5 10^3/uL	JN RY
Basophil #	0.0		0.0 - 0.1 10^3/uL	JN RY

Paul W. Wickard, PAC
Physician Assistant
FCI/FPC/FSL Jesup, Ga.

M. Chipi, MD
Medical Officer
FCI Jesup, Ga.

Legend
LO=Low AL=Alarm Low EL=Elevated Low HI=High AH=Alarm High EH=Elevated High AB=Abnormal

U.S. MEDICAL CENTERS FOR FEDERAL PRISONERS
Laboratory, 1900 W. Sunshine
SPRINGFIELD, MISSOURI 65808
(417) 862-7041

***** SENSITIVE-LIMITED OFFICIAL USE *****
FINAL REPORT

Register Number : 26864-039
Name : KELLY, LESLIE
Location : FCI JESUP (JES)
Admit. Physician: DR BURGOS
Order. Physician: DR BURGOS
Collected : 08/17/04 @ 11:15 by: RE

Coopermt

Age : 41yr
Sex : M
Room :
Accession Number : 6599

Test	Result	Flag	Reference Range/Units	Tech
COMP. METABOLIC				
Glucose	88		70 - 110 mg/dL	GK CK
Urea Nitrogen	14		7 - 22 mg/dL	GK CK
Creatinine	1.3		0.6 - 1.6 mg/dL	GK CK
SodiumI	141		137 - 148 mmol/L	GK CK
Potassium	4.4		3.5 - 5.0 mmol/L	GK CK
Chloride1	105		99 - 114 mmol/L	GK CK
Calcium1	9.2		8.5 - 10.9 mg/dL	GK CK
Total Protein	7.6		6.0 - 8.2 g/dL	GK CK
Albumin	4.2		3.6 - 5.1 g/dL	GK CK
Alkaline Phos.	79		41 - 133 U/L	GK CK
AST(SGOT)	29		11 - 55 U/L	GK CK
Total Bilirubin1	0.4		0.2 - 1.3 mg/dL	GK CK
Cholesterol	317	HI	140 - 200 mg/dL	GK CK
ALT1(SGPT)	90	HI	11 - 66 U/L	GK CK
Free T4	1.0		0.7 - 1.9 ng/dL	MS CK
TSH	0.92		0.30 - 7.00 uIU/mL	MS CK
CBC				
White Blood Cell	7.2		4.3 - 11.1 10^3/uL	WL CK
Red Blood Cells	5.60		4.46 - 5.78 10^6/uL	WL CK
Hemoglobin	15.5		13.6 - 17.6 g/dL	WL CK
Hematocrit	46.9		40.2 - 51.4 %	WL CK
MCV	83.7		82.5 - 96.5 fL	WL CK
MCH	27.6		27.1 - 34.3 pg	WL CK
MCHC	33.0		33.0 - 35.0 g/dL	WL CK
RDW	14.7	HI	12.0 - 14.0 %	WL CK
PLT	226		130 - 374 10^3/uL	WL CK
MPV	10.0		6.9 - 10.5 fL	WL CK
AUTODIFF				
Neutrophils	49.4		43.0 - 67.0 %	WL CK
Lymphocytes	42.9		21.0 - 45.0 %	WL CK
Monocytes	6.0		5.0 - 13.0 %	WL CK
Eosinophils	1.3		0.0 - 7.0 %	WL CK
Basophils	0.4		0.0 - 1.0 %	WL CK
Neutrophil #	3.5		1.9 - 6.7 10^3/uL	WL CK
Lymphocyte #	3.1		1.3 - 3.7 10^3/uL	WL CK
Monocyte #	0.4		0.3 - 1.1 10^3/uL	WL CK

Legend

LO=Low AL=Alarm Low EL=Elevated Low HI=High AH=Alarm High EH=Elevated High AB=Abnormal

Name : KELLY, LESLIE
Register Number : 26864-039
Printed : 08/18/2004 @ 14:18

Need meds

Location : JES
Page : 1 of 2

U.S. MEDICAL CENTERS FOR FEDERAL PRISONERS
Laboratory, 1900 W. Sunshine
SPRINGFIELD, MISSOURI 65808
(417) 862-7041

***** SENSITIVE-LIMITED OFFICIAL USE *****
FINAL REPORT

Register Number	: 26864-039	Age	: 41yr
Name	: KELLY, LESLIE	Sex	: M
Location	: FCI JESUP (JES)	Room	:
Admit. Physician	: DR BURGOS	Accession Number	: 6599
Order. Physician	: DR BURGOS		
Collected	: 08/17/04 @ 11:15 by: RE		

Test	Result	Flag	Reference Range/Units	Tech
Eosinophil #	0.1		0.0 - 0.5 10~3/uL	WL CK
Basophil #	0.0		0.0 - 0.1 10~3/uL	WL CK

Legend
LO=Low AL=Alarm Low SL=Elevated Low HI=High AH=Alarm High EH=Elevated High AB=Abnormal

GPO : 1988 O - 197-867

CLINICAL RECORD | **LABORATORY REPORTS**

ATTACH 3D REPORT ALONG HERE ↑ AND SUCCEEDING ONES ON ABOVE LINES

ATTACH 2D REPORT WITH TOP AT THIS LINE ↑

ATTACHING MARGIN

Kelly, Leslie

A/O

26864-039

USP Lewisburg
Health Service
Lewisburg, PA

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD

REQUESTING PHYSICIAN'S SIGNATURE: Bussanich

REPORTED BY:

REMARKS

Anthony Bussanich, M.D.
04/02/10

SPECIMEN/LAB RPT NO

URINALYSIS

URGENCY | PATIENT STATUS: ☐ A ☐ ENT ☐ DOM

SOURCE

(Specify)

PATIENTS MED. RECORD

ID: _____
835 04-02-01 13:03

CLARITY: _____
COLOR: YELLOW
GLU NEGATIVE
BIL NEGATIVE
KET NEGATIVE
SG >=1.030
BLO NEGATIVE
pH 5.0
PRO NEGATIVE
URO 0.2 E.U./dL
NIT NEGATIVE
LEU NEGATIVE

TESTS	SPECIMEN TAKEN: DATE	TIME: A.M. P.M.	RESULTS: REQUESTED (X)	ROUTINE	COLOR	SPECIFIC GRAVITY	UROBILINOGEN	OCCULT BLOOD	BILE	KETONES	GLUCOSE	PROTEIN	pH	MICROSCOPIC	WBC	RBC	EPITH CELLS	WBC	RBC

PATIENT

SSO-107

URINALYSIS

Standard Form 516 (Rev. 4-77) Prescribed by GSA and Administration and Interagency Committee on Records FIRMR (41 CFR) 201-45.505

LABORATORY REPORTS
Standard Form 516
Prescribed by GSA/ICMR FIRMR 41 CFR 201-45.505
October 1975 516-108

Kelly, Leslie

Laboratory Supervisor: ROCHESTER, MINNESOTA 55903
Daryl Aaberg (507) 287-0674

Printed: 04/05/2001 8:01:18

***** F I N A L R E P O R T *****

Name: KELLY, LESLIE [6283] ID: 26864-039

--Test Name----------	Result	Abnormal	Flag	Units	Reference Range
Collection Cmt.	Collected by Referring Institution				
PROFILE BUNDLE A					
COMP BLD CNT					
White Blood Ct	8.5			x10 3/ml	3.5 - 10.5
Red Blood Ct	6.05	HI		x10 6/ml	4.32 - 5.72
Hemoglobin	16.4			g/dl	13.5 - 17.5
Hematocrit	51.2	HI		%	38.8 - 50.0
MCV	85			fl	81 - 95
RDW	13.5			%	11.8 - 15.0
Platelet Ct	218			x10 3	150 - 450
RPR	Non-Reactive				Nonreact

-- End of Laboratory Report --

A/O

USP Lewisburg
Health Services Unit
Lewisburg, PA 17837

Anthony Bussanich MD 04/05/01

---------- S E N S I T I V E ----

Test(s) ordered: PROFILE BUNDLE A; COMP BLD CNT

ID : 26864-039 .....
Name: KELLY, LESLIE
Ordered By: Bussanich
Collected : 04/02/2001 07:00

DOB: 12/17/1962 Age: 38 Sex: M
Lab Acn#: 6283
Loc: USP Lewisburg, PA

Reviewed

BP-S622.060 **RADIOLOGIC CONSULTATION REQUEST/REPORT** CMM
JUL 99

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Patient Identification Name, Register Number, Institution	Age 42	Sex M	Examination Requested CTA
[illegible], LESLIE 26864-039	Pregnant ___Yes ___No		
	Diabetic ___Yes ___No		Unit
	Requested by [illegible]		Date Requested 8/13/04
Specific reason(s) for request (complaints and findings) ROUTINE			
Date of Examination 14240	Date of Report	Date of Transcription	Film# 14240

Radiologic Report

Kelley

PA AND LATERAL CHEST : The chest is unremarkable except for the presence of multiple metallic densities resembling bullet fragments which are projected over the scapula and right upper chest wall.

/S/ D & T: 08-26-04 Howard P. Schiele, M.D./rr Board Certified Radiologist

Signature	Location of Radiologic Facility

Original - Medical Record; Copy - Physician; Copy - Radiology
(This form may be replicated via WP)

This form replaces BP-S622 dtd AUG 96

Printed on Recycled Paper

BP-S622.060 RADIOLOGIC CONSULTATION REQUEST/REPORT CL 1
JUL 99

U.S. DEPARTMENT OF JUSTICE — FEDERAL BUREAU OF PRISONS

Patient Identification Name, Register Number, Institution	Age	Sex	Examination Requested
[illegible] 25864-039 12/17/62 / / F.C.I. JESUP, GA.	40	M	X-ray (R hand)
	Pregnant ___Yes ___No		
	Diabetic ___Yes ___No		Unit 5 Hu
	Requested by		Date Requested 7/4/04
Specific reason(s) for request (Complaints and findings)			
Date of Examination 7-23-4	Date of Report	Date of Transcription	Film# 14369

Radiologic Report

Kelly

RIGHT HAND: There is evidence of fracture identified through the base of the distal phalanx of the 5th digit with fragments separated approximately 3.0 mm.

IMPRESSION: FRACTURE, DISTAL PHALANX, RIGHT 5TH DIGIT.

/S/ D & T: 07-28-04 Thomas J. Payne, III, M.D./rr Board Certified Radiologist

[illegible] MD
FCI Jesup, GA

Signature	Location of Radiologic Facility

Original - Medical Record; Copy - Physician; Copy - Radiology

This form may be replicated via WP

This form replaces BP-S622 dtd AUG 96

FEDERAL TRANSFER CENTER
7420 S. MACARTHUR BLVD.
OKC, OK 73159

PATIENT NAME: Leslie Kelly

INMATE#: 26864 - 039

AGE: 41 years

ATTENDING PHYSICIAN: Dr. Goforth

DATE OF EXAMINATION: 05/24/04

EXAMINATION: Chest, single view.

FINDINGS:
Chest, single view, demonstrates heart size to be within normal limits. Both diaphragms are clean. Hilar vessels are within normal limits. No acute changes. There was noted numerous several radiopaque foreign bodies within the right axilla and in the area of the distal right clavicle, they have the overall appearance of bullet fragments.

IMPRESSION:
Chest, negative for acute changes. Numerous bullet fragments in the right axilla and distal right clavicle.

Released by: T. H. Molskness, D.O.

THM/ravindrat

J. Genzer
RN, ICC FTC
OKC, OK

PATIENT IDENTIFICATION NAME REGISTER NUMBER, INSTITUTION	AGE	SEX	MODIFIER	EXAMINATION REQUESTED	
KELLY, LESLIE **26864039** THE FEDERAL TRANSFER CENTER 7420 S MACARTHUR OKC,OK		**M**	**RIGHT**	**HAND THREE VIEWS**	73130-26
REQUESTED BY **THOMAS GOFORTH /**	PREGNANT **YES____NO_____**			DATE REQUESTED **05/27/04**	

SPECIFIC REASON FOR REQUEST
(COMPLAINTS AND FINDING)
719.4
PAIN IN JOINT

EXAMINATION DATE
05/27/04

RADIOLOGIC REPORT

ACCESSION NUMBER **26864-039**

ROOM NUMBER
1

SIGNATURE

LOCATION OF FACILITY
THE FEDERAL TRANSFER CENTER OKC,OK

(USE FOR FEMALE PATIENTS ONLY)

ARE YOU PREGNANT? / ESTA EMBARAZADA ?

YES/ SI_____ **NO**_____

Chris Reeves, RTR
Federal Transfer Center, OKC, OK

_____
SIGNATURE / FIRMA
DATE **05/27/04**

X-RAY LEAD APRON USED

SIGNATURE_____
DATE **05/27/04**

FEDERAL TRANSFER CENTER
7420 S. MACARTHUR BLVD.
OKC, OK 73159

PATIENT NAME: Leslie Kelly

INMATE#: 26864-039

AGE:

ATTENDING PHYSICIAN : Dr. Goforth.

DATE OF EXAMINATION: 05/27/04

EXAMINATION: Right hand, three views.

FINDINGS: Right hand, three views, demonstrates good bone density. There is noted presence of a small avulsed fracture extending from the base of the distal phalanx of the fifth digit on the dorsal side with slight separation of the fracture fragment. The rest of the hand is unremarkable.

IMPRESSION: Small avulsed fracture extending from the base of the distal phalanx of fifth digit on the dorsal side with slight separation of the fracture fragment.

Released by: T. H. Molskness, D.O.

THM/ravindrat

JUN 0 1 2004

Thomas F. Goforth, MD
FPC Oklahoma City, OK

BP-S622.060
U.S.DEPARTMENT OF JUSTICE

RADIOLOGIC CONSULTATION REQUEST/REPORT
FEDERAL BUREAU OF PRISONS

PATIENT IDENTIFCATION,NAME, REGISTER NUMBER, INSTITUTION	AGE	SEX	MODIFIER	EXAMINATION REQUESTED
KELLY, LESLIE **26864039** THE FEDERAL TRANSFER CENTER 7420 S MACARTHUR OKC,OK	41	M		**CHEST SINGLE VIEW** 71010-26

REQUESTED BY
THOMAS GOFORTH /

PREGNANT
YES____NO____

DATE REQUESTED
05/24/04

SPECIFIC REASON FOR REQUEST
(COMPLAINTS AND FINDING)
V01.1
TUBERCULOSIS SCREENING

EXAMINATION DATE
05/24/04

RADIOLOGIC REPORT

ACCESSION NUMBER 26864-039

ROOM NUMBER
2

SIGNATURE

LOCATION OF FACILITY
THE FEDERAL TRANSFER CENTER OKC,OK

(USE FOR FEMALE PATIENTS ONLY)

ARE YOU PREGNANT? / ESTA EMBARAZADA ?

YES/ SI_____ **NO**_____

Chris Reeves, RTR
Federal Transfer Center, OKC, OK

_____
SIGNATURE / FIRMA
DATE 05/24/04

X-RAY LEAD APRON USED

SIGNATURE_____
DATE 05/24/04

FEDERAL TRANSFER CENTER
7420 S. MACARTHUR BLVD.
OKC, OK 73159

PATIENT NAME: Leslie Kelly

INMATE#: 26864 - 039

AGE: 41 years

ATTENDING PHYSICIAN: Dr. Goforth

DATE OF EXAMINATION: 05/24/04

EXAMINATION: Chest, single view.

FINDINGS:
Chest, single view, demonstrates heart size to be within normal limits. Both diaphragms are clean. Hilar vessels are within normal limits. No acute changes. There was noted numerous several radiopaque foreign bodies within the right axilla and in the area of the distal right clavicle, they have the overall appearance of bullet fragments.

IMPRESSION:
Chest, negative for acute changes. Numerous bullet fragments in the right axilla and distal right clavicle.

Released by: T. H. Molskness, D.O.

THM/ravindrat

MAY 26 2004
Tom F. Goforth, MD
FTC Oklahoma City, OK

ID: 26864 039

09/10/04 9:51

D.O.B.: 12/17/1962 41
MALE
70 In. 205 lbs. B/P: 114/72
Meds:
Class:
Dr: BURGOS
Tech: GN

Vent. Rate:	66 bpm
P Duration:	104 ms
QRS Duration:	98 ms
PR Interval:	168 ms
QT Interval:	372 ms
QTc Interval:	383 ms
P-R-T AXIS:	59° 25° 13°

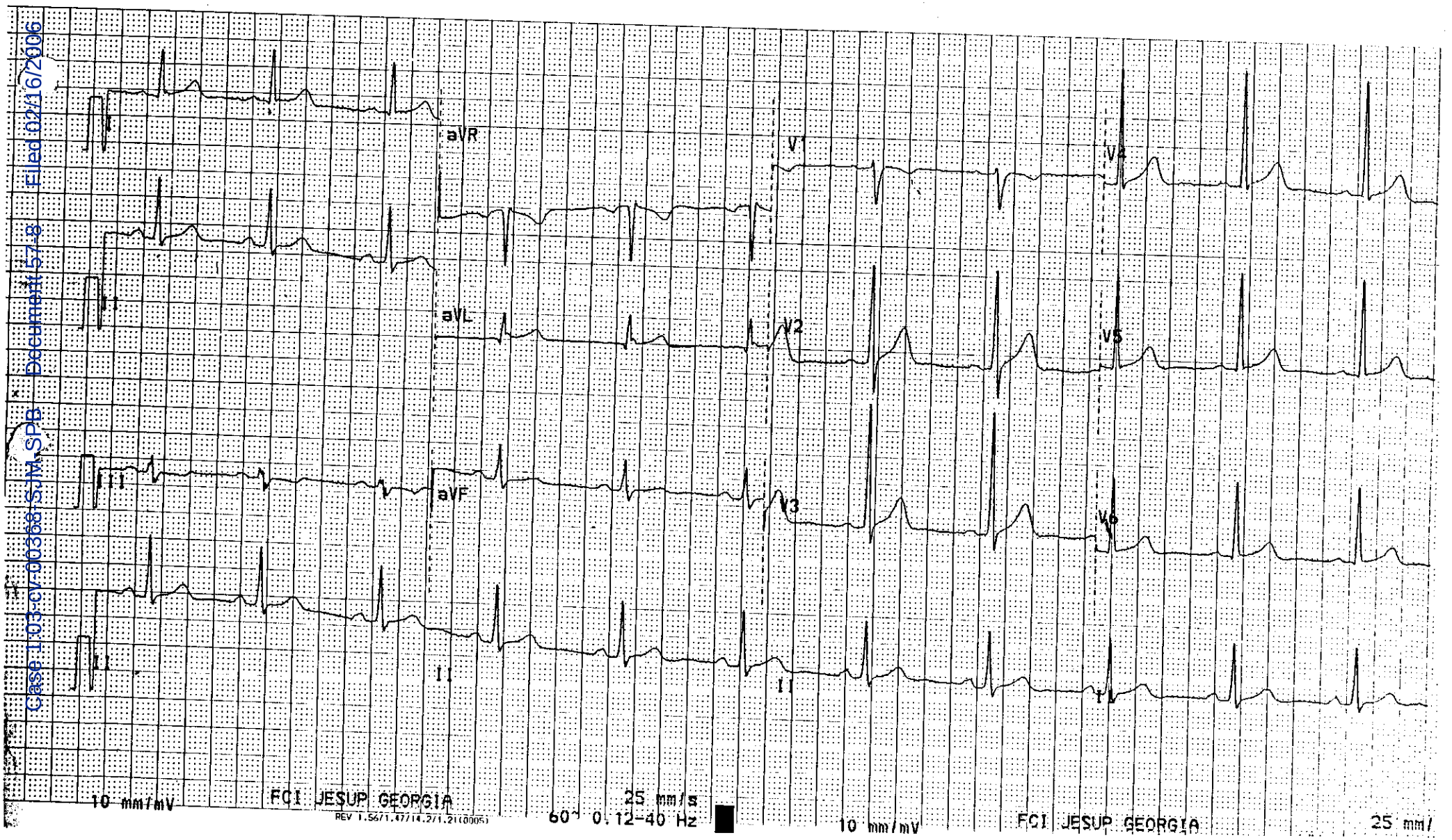
KELLY,LESLIE
ID: 26864 039

09/10/04 9:51

SINUS RHYTHM
WITHIN NORMAL LIMITS

Summary: NORMAL

* Unconfirmed Analysis



20804-039

23-Oct-2003 11:44:27
40 Years

KELLY
Male

REVIEWED BY:
H. BEAM, MD
FCI MCKEAN

10/23/03

FCI MC KEA

Operator: NN

Rate	80
PR	156
QRSD	94
QT	335
QTc	386

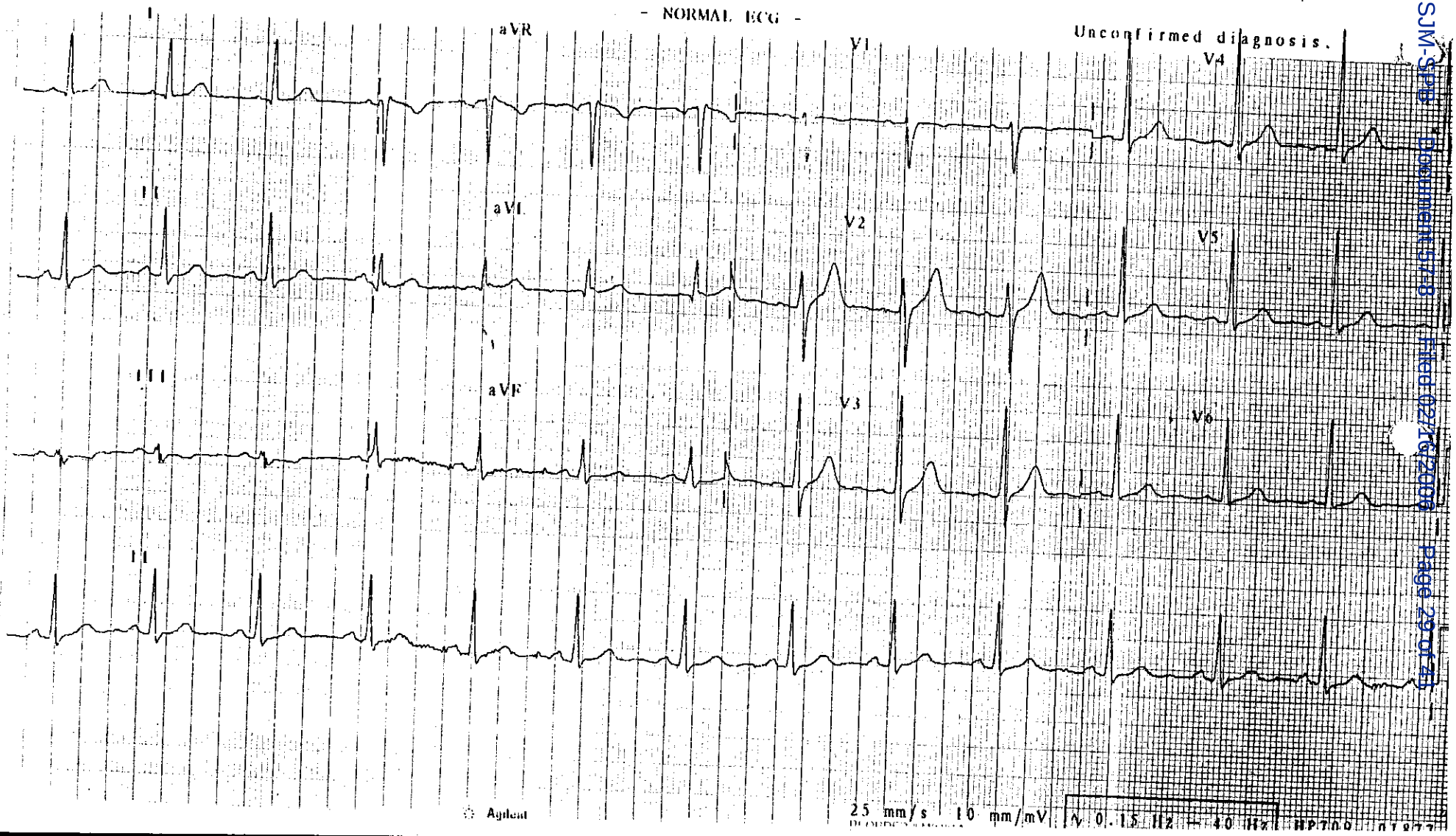
--Axis--

P	65
QRS	26
T	13

. NORMAL SINUS RHYTHM, RATE 80 . . . . . normal P axis, PR, r e & rhythm

- NORMAL ECG -

Unconfirmed diagnosis.



BP-S020.060 PATIENT PROBLEM LIST CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

PROBLEM LIST

DATE NOTED	SIGNIFICANT DIAGNOSES	SIGNIFICANT OPERATIONS/ INVASIVE PROCEDURES	DATE
4/6/04	Chronic H/A		
	HTN		
	hyperlipidemia		

ADVERSE / ALLERGIC DRUG REACTIONS
(If none, record "No Known Drug Allergies)

NKDA (3/30/01) 1-23-04 NKDA & Food Environment

Patient Identification
(Name, Reg #, DOB)

(This form may be replicated via WP)

DOB: 12/17/62

FOR: KEL[illegible] ID NO: [illegible] LOCATION: [illegible]
Height: 5'9". Allergies:
Weight: 175lbs. Diagnosis:

MEDICATION USES INSTRUCTIONS	RX NUM	QUAN	START DATE	LAST FILL REF AVAIL	EXP DATE PROVIDER
IBUPROFEN 600 MG TAB T1TTIDCF	106577	30	02/11/2005	02/11/2005 8	05/11/2005 WICKARD
ASPIRIN, E.C. 81 MG TAB T1TQD	106576	30	02/11/2005	02/11/2005 2	05/11/2005 WICKARD
LOVASTATIN 20 MG TAB T1T QPM WITH MEAL	106575	30	02/11/2005	02/11/2005 2	05/11/2005 WICKARD
METOPROLOL 50 MG TAB T1TBID	106574	60	02/11/2005	02/11/2005 2	05/11/2005 WICKARD
METOPROLOL 50 MG TAB T1TBID CF	101459	42	11/18/2004	01/26/2005 0	02/15/2005 WICKARD
IBUPROFEN 600 MG TAB T1TTIDCF	101460	30	11/18/2004	01/21/2005 6	02/15/2005 WICKARD

BP-S619.060 **IMMUNIZATION RECORD** CDFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TETANUS TOXOIDS

DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION

TUBERCULIN TESTS

DATE GIVEN	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER/ INSTITUTION	DATE READ	RESULTS (MM)	READ BY
12-31-01	Tubersol	C0521AA	3/02	LFA	0.1 ml ID	USP LEW	1-3-02	0 mm	[illegible]
1/8/03	Parkedale	00272P	10/03	(L) FA	0.1 cc ID	[illegible]	1/10/03	0	[illegible]
1/6/04	Park.	00243P	7/04	(L) FA	0.1 cc ID	[illegible]	1/8/04	0	BAD
01-25-05	Aventis	C1678AA	02-10-06	(L) FA	0.1 ml ID	[illegible] FCE Jesup	01-27-05	0 mm	[illegible]

Patient Identification
(Name, Reg #)

(This form may be replicated via WP)

Revised 10/65
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.806-6

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME: Kelly, Leslie	2. GRADE AND COMPONENT OR POSITION: [illegible] 26
4. HOME ADDRESS (Number, street or R FD, city or town, State and ZIP Code)	5. PURPOSE OF EXAMINATION: A/o physical
	6. DATE OF EXAMINATION: 3/30/[illegible]
7. SEX: Male	8. RACE: Black
9. TOTAL YEARS GOVERNMENT SERVICE — MILITARY / CIVILIAN	10. AGENCY
	11. ORGANIZATION UNIT
12. DATE OF BIRTH: 12/17/72	13. PLACE OF BIRTH: Detroit, M[illegible]
14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN: Shirita Kellie (Sister) 16679 Cruse Detroit, Michigan 48235	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS: USP LEWISBURG HEALTH SERVICES UNIT LEWISBURG, PA 17837	16. OTHER INFORMATION
17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total) / LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (Ext. & ext. canals) (Auditory acuity under items 70 and 71)	
✓	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 58, 60 and 62)	
✓	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (Equality and reaction)	
✓	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
✓	29. HEART (Thrust, size, rhythm, sounds)	
✓	30. VASCULAR SYSTEM (Varicosities, etc.)	
✓	31. ABDOMEN AND VISCERA (Include hernia)	
✓	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
✓	33. ENDOCRINE SYSTEM	
✓	34. G-U SYSTEM	
✓	35. UPPER EXTREMITIES (Strength, range of motion)	
✓	36. FEET	
✓	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	38. SPINE, OTHER MUSCULOSKELETAL	
✓	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (Equilibrium tests under item 72)	
✓	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable teeth · Non-restorable teeth · Missing teeth · Replaced by dentures · Fixed Partial dentures

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS A. SPECIFIC GRAVITY
B. ALBUMIN
C. SUGAR
D. MICROSCOPIC

46. CHEST X-RAY (Place, date, film number and result)

47. SEROLOGY (Specify test used and result)

48. EKG

49. BLOOD TYPE AND RH FACTOR

50. OTHER TESTS

88-118

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD	56. TEMPERATURE
5'11"	200lb.	Black	Black	☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	98.2°f

57. BLOOD PRESSURE (Arm at heart level)

	A. SITTING	B. RECUMBENT	C. STANDING (5 min.)
SYS.	145		
DIAS.	96		

58. PULSE (Arm at heart level)

A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
98				

59. DISTANT VISION		60. REFRACTION		61. NEAR VISION	
RIGHT 20/ 20	CORR. TO 20/	BY	S. CX	CORR. TO	BY
LEFT 20/ 20	CORR. TO 20/	BY	S. CX	CORR. TO	BY

62. HETEROPHORIA (Specify distance)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (Test used and result)	65. DEPTH PERCEPTION (Test used and score)	
RIGHT	LEFT	WNL Pseudoisochromatic plegues		UNCORRECTED
				CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (Test used and score)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 3896	4000 4096	6000 6144	8000 8188	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

Cultural, psychosocial, spiritual, or personal values which may impact on health care decisions: None

Emotional barriers, motivation to learn, cognitive or communicative limitations which may impact on patient education: None

O smoker since three years ago.

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

Essentially healthy male.

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINER (Check)

A. ☑ IS QUALIFIED FOR Regular housing and duties

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

A	B	C	E

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Luis Ramirez, P.A.	Luis Ramirez, P.A.
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
Anthony Bussanich, M.D.	
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

☆ U.S. GOVERNMENT PRINTING OFFICE : 1977—O-241-530 #3377

U.S. DEPARTMENT OF JUSTICE — FEDERAL BUREAU OF PRISONS — MAY

THIS INFORMATION IS FOR OFFICIAL AND MEDICAL CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME	2. REGISTER NUMBER
Kelly Leslie Lorello	26564039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINATION FACILITY

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATION CURRENTLY USED (Follow by description of past history, if complaint arises)

7. HAVE YOU EVER (Please check each item)

YES	NO	(Check each item)
	✓	Lived with anyone who had tuberculosis
	✓	Cough up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

8. DO YOU (Please check each item)

YES	NO	(Check each item)
✓		Wear glasses or contacts lens
✓		Have vision in both eyes
	✓	Wear hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	✓		Scarlet fever		✓		Adverse reaction to				Epilepsy or fits
	✓		Rheumatic fever		✓		drug or medicine				Car, train, sea or air sickness
✓			Swollen or painful			✓	Broken bones				Frequent trouble sleeping
✓			joints		✓		Tumors, growth, cyst, cancer				Depression or excessive worry
	✓		Frequent or severe		✓		Rupture/hernia				Loss of memory or amnesia
✓			headache		✓		Piles or rectal disease				Nervous trouble of any sort
	✓		Dizziness or fainting		✓		Frequent or				Periods of unconsciousness
	✓		spells		✓		painful urination				Have you ever had
	✓		Eye trouble		✓		Bed wetting since age 12				homosexual contact?
	✓		Ear, nose, throat trouble		✓		Kidney stone or				Been exposed to AIDS
	✓		Hearing loss		✓		blood in urine				Alcohol Use (Excessive)
	✓		Chronic, frequent colds		✓		Sugar, albumin in urine				Drug Use/Addiction
	✓		Severe tooth, gum trouble		✓		VD-Syphilis, gonorrhea,				Marijuana
	✓		Sinusitis		✓		etc.				Cocaine
	✓		Hay Fever		✓		Recent gain or loss of				Heroin
	✓		Head injury		✓		weight				L.S.D.
	✓		Skin disease		✓		Arthritis, Rheumatism,				Amphetamines
	✓		Thyroid trouble		✓		or Bursitis				Others: (Specify)
	✓		Tuberculosis	✓			Bone, joint or				
	✓		Asthma				other deformity				Alcohol or drug
			Shortness of breath		✓		Lameness				Withdrawal Problems
			Pain, pressure in chest		✓		Loss of finger or toe				

(This form may be replicated via WP)

This form replaces BP-360(60) dated January 1986

			Chronic cough				Spinal or "trick"					
			Palpitation or pounding				shoulder or elbow	10. FEMALES ONLY HAVE YOU EVER				
			heart				Recurrent back pain				Been treated for a	
			Heart trouble				"trick" or locked				female disorder	
			High or Low blood	✓			Foot trouble				Had a change in	
			pressure				Neuritis				menstrual pattern	
			Cramps in your legs				Paralysis (include				ARE YOU PREGNANT	
			Frequent indigestion				infantile)				SUSPECT YOU ARE	
			Stomach, liver, or				Gall bladder trouble				PREGNANT	
			intestinal trouble				or gallstones					
			Jaundice or hepatitis									

11. WHAT IS YOUR OCCUPATION?

12. ARE YOU (check one) ☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or bee unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury notes? (If yes, specify when, where, and gi-e details.)
	✓	B. Inability to perform certain motions.			
	✓	C. Inability to assume certain positions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
	✓	D. Other medical reasons (If you, give reasons.)			
	✓	14. Have you, ever been treated for mental condition? (If yes, specify when, where, and give details.)		✓	20. Have you ever been rejected for military service because of physical, mental or other reason? (If yes, give date, and reason for rejections>)
	✓	15. Have you ever been denied life insurance? Reason give details.)		✓	21. Have your ever been discharged from military service because of physical mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
	✓	16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, what amount, when, why.)
	✓	17. Have you ever been a patient in any type of hospital? (If yes, specify when, where why, and name of doctor and complete address of hospital.)			

I certify that I have reviewed the forgoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of my doctors, hospitals, or clinics mentioned above to furnish the government a complete transcript of my medical record.

TYPED OR PRINTED NAME OR EXAMINEE | SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT_____TRANSFER _____P.V._____

OTHER _____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG HOW MUCH, HOW OFTEN HOW USED. WHEN WERE THEY LAST USED:

HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? _____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ____ NO ____

WHAT ARRANGEMENTS HAVE BEEN MADE? _____

DUTY STATUS: TEMPORARY WORK ____ RESTRICTED _____

GENERAL POPULATION _____YES _____ NO _____

TYPE EXTENT OF LIMITATION _____

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

TYPE OR PRINT NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
L. T. Genzer, RN TC, OKC	MAY 24 2004		

Food or Drug Allergies: NKA: Allergies: _____

Current Medical Status: No Complaints: Complaint of _____

TB Signs and Symptom(s): None; cough, hemoptysis, night sweats, wt. loss

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. REGISTER NUMBER
Kelly, Leslie	26864-039

3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
Intake screening	3/30/01	USP Lewisburg, Lewisburg PA 17837

6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint arises)*

No meds.
No med. complaints at this time.

7. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
	√	Lived with anyone who had tuberculosis
	√	Coughed up blood
	√	Bled excessively after injury or tooth extraction
	√	Attempted suicide
	√	Been a sleepwalker

8. DO YOU *(Please check each item)*

YES	NO	(Check each item)
	√	Wear glasses or contact lenses
√		Have vision in both eyes
	√	Wear a hearing aid
	√	Stutter or stammer habitually
	√	Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
	√		Scarlet fever
	√		Rheumatic fever
	√		Swollen or painful joints
	√		Frequent or severe headache
	√		Dizziness or fainting spells
	√		Eye trouble
	√		Ear, nose, or throat trouble
	√		Hearing loss
	√		Chronic or frequent colds
	√		Severe tooth or gum trouble
	√		Sinusitis
	√		Hay Fever
	√		Head injury
	√		Skin diseases
	√		Thyroid trouble
	√		Tuberculosis
	√		Asthma
	√		Shortness of breath
	√		Pain or pressure in chest
	√		Chronic cough
	√		Palpitation or pounding heart
	√		Heart trouble
	√		High or low blood pressure
	√		Cramps in your legs
	√		Frequent indigestion
	√		Stomach, liver, or intestinal trouble
	√		Gall bladder trouble or gallstones
	√		Jaundice or hepatitis

YES	NO	DON'T KNOW	(Check each item)
	√		Adverse reaction to serum drug or medicine
	√		Broken bones
	√		Tumor, growth, cyst, cancer
	√		Rupture/hernia
	√		Piles or rectal disease
	√		Frequent or painful urination
	√		Bed wetting since age 12
	√		Kidney stone or blood in urine
	√		Sugar or albumin in urine
	√		VD—Syphilis, gonorrhea, etc.
	√		Recent gain or loss of weight
	√		Arthritis, Rheumatism, or Bursitis
	√		Bone, joint or other deformity
	√		Lameness
	√		Loss of finger or toe
	√		Painful or "Trick" shoulder or elbow
	√		Recurrent back pain
	√		"Trick" or locked knee
	√		Foot trouble
	√		Neuritis
	√		Paralysis (include infantile)

YES	NO	DON'T KNOW	(Check each item)
	√		Epilepsy or fits
	√		Car, train, sea or air sickness
	√		Frequent trouble sleeping
	√		Depression or excessive worry
	√		Loss of memory or amnesia
	√		Nervous trouble of any sort
	√		Periods of unconsciousness
	√		Have you ever had homosexual contact?
	√		Been exposed to AIDS
	√		Alcohol Use (Excessive)
	√		Drug Use/Addiction
√			Marijuana
√			Cocaine
	√		Heroin
	√		L.S.D.
	√		Amphetamines
	√		Others: (Specify)
	√		Alcohol or drug Withdrawal Problems

10. FEMALES ONLY HAVE YOU EVER

N/A	Been treated for a female disorder
	Had a change in menstrual pattern
	ARE YOU PREGNANT
	SUSPECT YOU ARE PREGNANT

11. WHAT IS YOUR USUAL OCCUPATION?
Exterminating company.

12. ARE YOU (Check one)
☑ Right handed ☐ Left handed

BP-360(60)

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
	✓	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		✓	18. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	B. Inability to perform certain motions.	✓		19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	C. Inability to assume certain positions.			
	✓	D. Other medical reasons *(If yes, give reasons.)*		✓	20. Have you ever been rejected for military service because of physical, mental, or other reason? *(If yes, give date, and reason, for rejections.)*
	✓	14. Have you, ever been treated for a mental condition? *(If yes, specify when, where, and give details).*			
	✓	15. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		✓	21. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	16. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occured.)*			
✓		17. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		✓	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? *(If yes, specify what kind, granted by whom , and what amount, when, why.)*

EXPLANATION: (#13-22 ABOVE)

17- 10yrs. ago Southfield Michigan for a GSW.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
Leslie Kelly	Leslie Kelly

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT ___ TRANSFER ✓ P V. ___

OTHER ___

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED, WHEN WERE THEY LAST USED: HAVE

THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? N/A

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES ___ NO ✓

WHAT ARRANGEMENTS HAVE BEEN MADE? None

DUTY STATUS: TEMPORARY WORK ✓ RESTRICTED ___

GENERAL POPULATION ___ YES ___ NO ___

TYPE AND EXTENT OF LIMITATION ___

23. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

BP 360 was completed today.
F/M is essentially healthy.

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
Luis Ramirez, P.A.	3/30/01	Luis Ramirez PA.	

REVERSE

BP-S354.060 INTAKE SCREENING (MEDICAL) CDFRM
NOV 94
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
	7-16-04	0800

Inmate's Name	Register Number
KELLY, LESLIE	26864-039

MEDICAL CLEARANCE

12/17/62

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

FCI JESUP, GA.

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☐ yes; ☐ no (Explain)

N/A

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
Brad Tucker, RN FCI/FPC Jesup GA	7-16-04	0800

Medical Staff Title

RN

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994

D1

BP-S354.060 **INTAKE SCREENING (MEDICAL)** CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
FDC, TALLAHASSEE	JUNE 29, 2004	1800

Inmate's Name	Register Number
KELLY, LESLIE	26864-039

M E D I C A L C L E A R E N C E

1. BP-149(60) reviewed? X yes; ☐ no (Explain)

2. General Population Housing Approved? X yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? X yes; ☐ no (Specify limitations or exclusions)

NO FOOD SERVICE UNTIL MEDICALLY CLEARED

4. For Holdovers: OK for Continued Transport? X yes; ☐ no (Explain)

5. Disabilities? ☐ yes X no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks: LICE: NONE NOTED
PPD STATUS: 1-8-04 Okm
CXR
MEDICATION: ~~NO~~ YES SEE T/

ALLERGIES: NKDA
SUICIDAL: YES (NO)
OTHER:

Medical Staff Signature	Date	Time
	JUNE 29 , 2004	1930

Medical Staff Title EDWARD CONNELLY, JR. PA-C
~~CANDICE MITCHELL, PARAMEDIC~~

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP) Replace BP-354(60) of APRIL 1990 and BP-S354 of AUG 1994

BP-S354 INTAKE SCREENING (MEDICAL) CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution	Date of Arrival	Time of Arrival
USP Lewisburg	5-21-04	1300

Inmate's Name	Register Number
Kelly, Leslie	26864-039

MEDICAL CLEARANCE

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)

2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)

3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations or exclusions)

4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)

5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature	Date	Time
[signature]	5-21-04	1443

Medical Staff Title
C Rotter Pharmacist

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)

Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994